

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055850	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Pine Ridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 45 Professional Center Pkwy San Rafael, CA 94903	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure the Consulting Pharmacist conducted a monthly Medication Regimen Review (MRR- the process by which a Consultant Pharmacist reviews medication used for a patient and identifies medications that may no longer be necessary or may be more appropriate in a lower dose) for a census of 81 residents. This failure decreased the facility's potential to ensure residents were not administered unnecessary medications that can cause serious side effects or adverse consequences. Findings: During a review of the MRR facility binder on 12/4/25 at 9:21 a.m., the Consulting Pharmacist's October 2025 MRR report was not observed in the MRR. During an interview with the Director of Nursing (DON) on 12/5/25 at 11:30, a copy of the October 2025 MRR report was requested and was not received prior to the survey team exiting the facility. The DON stated she did not have a copy of the Consultant Pharmacist's October 2025 MRR because the Consultant Pharmacist was out on paternity leave during that month. On 12/10/25 the DON emailed the surveyor a copy of the October 2025 MRR report. According to the report, the Consultant Pharmacist reviewed a total of 67 resident medication lists and had zero recommendations. A review of the facility's policy and procedure titled, Medication Monitoring Medication Regimen Review and Reporting, dated 2007, indicated, The consultant pharmacist reviews the medication regimen and medical chart of each resident at least monthly to appropriately monitor the medication regimen and ensure that the medications each resident receives are clinically indicated. Identification of irregularities may occur by the consultant pharmacist utilizing a variety of sources including medication administration records (MAR), prescriber's orders, progress notes, nurse's notes, and Resident Assessment Instrument (RAI), Minimum Data Set (MDS), laboratory and diagnostic test results, behavior monitoring information and information from the nursing care center staff and other health professionals involved in the resident's care. A record of the consultant pharmacist's observations and recommendations is made available in an easily retrievable format to nurses, physicians, and the care planning team within 48 hours of MRR completion.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions and in accordance with professional standards for food service safety for a census of 83 when:1. One cook did not cover his beard while working around food in the kitchen;2. Prepared sandwiches were unlabeled and undated in Refrigerator 1 and an open bag of chicken breasts was unlabeled and undated in Freezer 1;3. Two seasoning containers were past their use-by dates;4. Sealed cardboard boxes labeled Mashed Potatoes, received 11/26/25, were found directly on the floor in dry storage area on 12/2/25; and5. A manual can opener had missing metal on the tip of the blade. These failures had the potential to contribute to the spread of foodborne illnesses among a vulnerable resident population.Findings:1. During the initial kitchen tour on 12/2/25 at 9:49 a.m., [NAME] 1 (CK 1) was observed in the kitchen prep area without a beard restraint or face mask. CK 1 had a full-face beard extending from ear to ear, covering half of the cheeks, jawline, and chin, with dense facial hair approximately 0.25 inches in length. During an interview on 12/2/25 at 10:10 a.m., the Dietary Manager (DM) stated the facility did not have any beard restraints available for staff use.During a review of the facility's policy and procedure (P&P) titled, Food Handling Practices, undated, indicated staff must use proper food handling techniques and practice personal hygiene, including restraining hair.During a review of the U.S. Food and Drug Administration's (FDA) Food Code, 2022 version, section 2-402.11 indicated, food workers must wear hair restraints, including beard restraints, to keep hair away from food and equipment.2. During the initial kitchen tour on 12/2/25 at 9:47 a.m., approximately 21 cheese sandwiches in Refrigerator # 1 were observed to be undated and unlabeled. During an interview on 12/2/25 at 9:49 a.m. with the Dietary Aide (DA) and CK 1, the DA stated she did not know when they were made and CK 1 stated they were made yesterday. During the initial kitchen tour on 12/2/25 at 9:53 a.m., an open plastic bag of chicken breasts was found in Freezer #1 without a label or date.During an interview on 12/3/25 at 9:58 a.m., with the Registered Dietitian (RD) and DM, the RD and DM both said foods must be labeled and dated, and that having unlabeled foods-especially raw chicken-was not acceptable because it increases the risk of residents getting sick.Review of the FDA Food Code (2022) section 3-501.17 indicated, opened or prepared food must be labeled with the date it was opened or prepared and discarded by the proper date.3. During the initial kitchen tour on 12/2/25 at 9:57 a.m., a container of sage and another unlabeled container of dried green herbs were found with use-by dates of 11/27/25.During an interview on 12/3/25 at 10:08 a.m., with the DM and RD, the DM and RD confirmed there had been expired herbs available for use in the kitchen. The DM stated it was important to use items by their use by dates and added, If items are not fresh it can pose potential sickness, nausea, upset stomach can occur for the residents.Review of the FDA Food Code (2022) section 3-501.17 indicated, food establishments must not use items beyond the manufacturer's intended use-by date to maintain quality and prevent safety risks.4. During the initial kitchen tour on 12/2/25 at 9:59 a.m., boxes labeled Mashed Potatoes, received 11/26/25, were found directly on the floor in the dry storage area. During an interview on 12/3/25 at 10:08 a.m., the DM stated food may be contaminated if kept on the floor because the floor is not sanitary. During a review of the facility's P&P titled, Receiving Foods, undated, indicated, food items should be placed in appropriate storage areas as quickly as possible.5. During an observation of the kitchen on 12/4/25 at 10:20 a.m., the can opener was observed with metal having worn off the tip of the blade and food build-up above the tip.During an interview on 12/4/25 at 10:23 a.m., the DM agreed the blade looked worn and could pose a possible infection control problem.Review of the FDA Food Code (2022) section 4-501.11 indicated, can-opener blades must be sharp to prevent metal fragments from breaking off into food.Review of the FDA Food Code (2022) section 4-202.15 indicated, can openers that become pitted or unable to be cleaned must be replaced because they can no longer be properly sanitized.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to inform and offer written information regarding Advance Directives (AD-a legal document which specifies healthcare wishes and appoints someone to make decisions in cases of an inability to communicate with the healthcare team) to 9 residents (Residents 45, 2, 67, 76, 6, 73, 16, 53, and 84) out of a census of 83 residents when there was no documented evidence of written or verbal information was communicated to each resident regarding the formulation and execution of an AD upon admission or thereafter as legally mandated. This failure decreased the facility's potential to provide care consistent with residents' wishes should they become incapacitated. Findings: A review of Resident 45's Physician Orders for Life-Sustaining Treatment (POLST- a form which indicates residents' preferences for life sustaining treatment in the event of a medical emergency), dated [DATE], indicated Resident 45 had no AD on file. A review of Resident 45's Electronic Medical Record (EMR) indicated no documented evidence that facility staff informed or offered Resident 45 or his Responsible Party (RP- an individual or entity legally accountable for specific financial, legal, and health care obligations) information regarding an AD. A review of Resident 2's POLST, dated [DATE], indicated he had no AD on file. A review of Resident 2's EMR indicated no documented evidence that facility staff informed or offered Resident 2 or his RP information regarding an AD. A review of Resident 67's POLST, dated [DATE], indicated Resident 67 elected for staff not to conduct cardiopulmonary resuscitation (CPR) which made Resident 67's CPR status as Do Not Resuscitate (DNR)- medical orders directing healthcare providers not to provide any life sustaining treatment). A review of Section D (information regarding AD status) of this POLST was left blank. A review of Resident 67's Electronic Medical Record (EMR) indicated no documented evidence that facility staff informed or offered Resident 67 or his RP information regarding an AD. A review of Resident 76's POLST, dated [DATE], indicated Resident 76's CPR status was DNR. A review of Section D of this POLST was left blank. A review of Resident 76's EMR indicated no documented evidence that facility staff informed or offered Resident 76 or his RP information regarding an AD. A review of Resident 6's POLST, dated [DATE], indicated he had no AD on file. A review of Resident 6's EMR indicated no documented evidence that facility staff informed or offered Resident 6 or his RP information regarding an AD. A review of Resident 73's POLST, dated [DATE], indicated he had no AD on file. A review of Resident 73's EMR indicated no documented evidence that facility staff informed or offered Resident 73 or his RP information regarding an AD. A review of Resident 16's POLST, dated [DATE], indicated Resident 16 elected to receive CPR and full treatment interventions if she was found without a pulse and not breathing. A review of Section D of this POLST was blank. A review of Resident 16's EMR indicated no documented evidence that facility staff informed or offered Resident 16 or his RP information regarding an AD. A review of Resident 53's POLST, dated [DATE], indicated Resident 53's CPR status was DNR. A review of Section D of this POLST was blank. A review of Resident 53's EMR indicated no documented evidence that facility staff informed or offered Resident 53 or his RP information regarding an AD. A review of Resident 84's EMR on [DATE] at 3:29 p.m., indicated he had no AD or POLST on file and no documented evidence that facility staff informed or offered Resident 84 or his RP information regarding an AD. During an interview on [DATE] at 9:08 a.m., the Director of Nursing (DON) stated AD and POLST were not the same. The DON stated a POLST was an order from the physician for life sustaining treatment, and an AD was a document which described measures for treatment the residents preferred when they are unable to make decisions for themselves. The DON further stated the Social Services Director (SSD) should have a conversation with the residents regarding ADs upon admission and the conversation should be documented in the residents' EMR. During an interview on [DATE] at 9:15 a.m., the SSD stated she offered ADs to the residents and families when they arrived. The SSD stated she often (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gave them a blank AD form to fill out if they want to move forward with establishing an AD. The SSD stated, I do not document these conversations. because many times it's an emotional issue to talk about death or incapacitation [for the resident and family].A review of a blank POLST form indicated, POLST does not replace the Advance Directive. When available review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.It is recommended that POLST be reviewed periodically. Review is recommended when.The patient is transferred from one care setting.to another, or.There is a substantial change in the patient's health status, or.The patient's treatment preferences change.A review of the facility's policy titled Advance Directives, undated , indicated, The resident has the right to accept or refuse medical or surgical treatment and to formulate an Advance Directive in accordance with state and federal law.Upon admission, the Company will provide a resident or the resident's representative with written information regarding the Company's policy on Advance Directives and a copy of this policy.If a resident has not executed an Advance Directive and the resident has capacity to make health care decisions, the social services department should contact the resident to determine whether the resident wishes to make an Advance Directive .If a resident.does not have capacity to do so at the time of admission, then the Company must follow state law to determine who has authority to make health care decisions on behalf of the resident.The Company must document in a prominent part of the resident's clinical record whether the resident has issued an Advance Directive.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interviews and record reviews, the Interdisciplinary Team (IDT, a group of professionals from different fields who work closely and collaboratively to coordinate care to achieve resident goals) failed to meet as a complete team to provide quarterly care conferences for four residents (Resident 5, Resident 76, Resident 67, and Resident 3) of 21 sampled residents. This failure resulted in a lack of oversight to determine whether resident goals were achieved and what revisions needed to be made to assist the residents to achieve their goals. Findings: A review of Resident 5's face sheet indicated admission to the facility on 6/20/25 with a diagnosis of Cerebral Infarction due to unspecified occlusion or stenosis of left middle cerebral artery (also known as an ischemic stroke, happens when a blood clot blocks an artery supplying the brain, cutting off oxygen and nutrients, causing brain cells to die), Unspecified dementia (a person has dementia symptoms (memory loss, confusion, personality changes), but the specific cause or type isn't clear, Hemiplegia unspecified affecting right dominant side (paralysis affecting one side of the body), and Aphasia (a language disorder from brain damage (often stroke) that affects speaking, understanding, reading, and writing, but not intelligence. A review of Resident 5's Minimum Data Set (MDS, an assessment tool) dated 9/24/25 indicated Resident 5 had a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 2 which indicated severe cognitive impairment. A review of Resident 5's physician progress notes dated 10/14/25 indicated, [Resident 5] does not have capacity to make health care decisions. A review of Resident 5's care plans on 12/2/25 indicated care plans initiated between 6/20/25 and 9/30/25 had not been revised. A review of Resident 76's face sheet indicated admission to the facility on 8/30/22 with a diagnoses of Adult Failure to Thrive (a state of significant physical and functional decline in older adults), Community Acquired Pneumonia (a lung infection contracted outside of the facility) and Severe Protein Calorie Malnutrition (a condition resulting from insufficient absorption of protein and energy leading to physical decline and increased risk of infection). A review of Resident 76's IDT Care Conference notes indicated Resident 76 had care conferences (meetings where the interdisciplinary team meets to discuss, develop or revise the comprehensive plan of care with the resident and/or resident representative) on 6/13/23 and 9/14/23. There was no documented evidence that care conferences were held for 4th quarter of 2022, 1st quarter of 2023, 4th quarter of 2023, all quarters of 2024 and all quarters of 2025 to date. A review of Resident 67's face sheet indicated admission to the facility on 2/4/25 with diagnoses of hemiplegia (complete paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following a cerebral infarction (stroke) affecting right dominant side, repeated falls and post-traumatic stress disorder (a mental health disorder that can develop after experiencing or witnessing a life threatening or shocking traumatic event). A review of Resident 67's IDT Care Conference notes indicated Resident 67 had care conferences on 2/17/25 and 5/8/25. There was no documented evidence of care conferences being held for the 3rd and 4th quarter to date. A review of Resident 3's face sheet indicated admission to the facility on 7/14/25 with a diagnosis of vascular dementia (a decline in thinking skills caused by conditions that damage blood vessels and reduce blood flow to the brain, leading to problems with memory, planning, judgment and mood). A review of Resident 3's IDT Care Conference notes indicated Resident 3 had a care conference on 7/18/25. There was no documented evidence of care conferences being held for the 3rd and 4th quarter to date. During an interview on 12/4/25 at 11:02 a.m., the Social Services Director (SSD) stated she was behind [with care conferences] on long term people about a month or two across the board. The SSD acknowledged IDT care conferences should occur at least every quarter and the purpose of them is to review the plan of care with the resident and/or resident representative and assess if it needed to be revised, and to see if the resident had any new goals. During a concurrent interview and record review on 12/4/25 at 4:04 p.m., the MDS (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinator (MDS 1) stated IDT meetings are conducted quarterly and usually consisted of the Social Worker, the MDS Coordinator, and other team members when available. The residents and family are invited with family attending on the telephone. During a review of Resident 5's medical record, MDS 1 confirmed there was no documented evidence of care conferences or IDT meeting notes located in Resident 5's medical records. During a review of the facility's operations policy and procedure titled, Care Plan Conference undated, indicated, The comprehensive plan of care must be developed by an [IDT] that includes the attending physician, a registered nurse, and other appropriate staff as determined by the resident's needs; Be periodically reviewed and revised by the [IDT] as changes in the resident's care and treatment occur; Reflect participation of the resident, the resident's family, or the resident's legal representative. Re-evaluate and modify care plans as necessary to reflect changes in care, service, and treatment; quarterly, annually. Ensure that care plan evaluation includes the following. The status of progress toward goal achievement is documented in the [IDT] Progress Notes as part of the resident's medical record. Participants date and sign the care plan evaluation.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews, and record review, the facility failed to serve food that was palatable, attractive, and appetizing for 6 residents (Resident 51, Resident 63, Resident 70, Resident 75, Resident 89, and Resident 90) of 21 sampled residents when they complained the food was terrible and dissatisfying. This failure decreased the facility's potential to prevent unplanned weight loss and could negatively affect the health and well-being of the affected residents. Findings: During an interview on 12/2/25 at 10:50 a.m., Resident 89 stated, The food is horrible; I'm on a pureed diet. [It] Seems nutritious, but they don't tell you what you are eating. I get a green dish, a gray dish, an orange dish. During an interview on 12/2/25 at 10:57 a.m., Resident 63 complained the meat was sometimes too hard to chew. During an interview on 12/2/25 at 11:48 a.m., Resident 75 stated, [The] Food is awful. During an interview on 12/2/25 at 2:41 p.m., Resident 70 stated, [The] Food here is best described as pathetic. During an interview on 12/3/25 at 8:38 a.m., Resident 90 stated, Food was so-so. The pureed diet had lumps and was not very tasty. During an observation on 12/3/25 at 1:15 p.m., the Department sampled a test tray of the facility's lunch service, which included Herb Baked Fish, Bowtie Pasta, Broccoli with Cheese Sauce, and a Wheat Roll. Both regular and pureed diet trays were evaluated. The regular tray was noted to be bland, and the cheese sauce on the broccoli lacked detectable flavor. The pureed tray was observed to be unappetizing in appearance, lacking in taste, and the pasta had a gummy texture, which adhered to the roof of the mouth during sampling. During an interview on 12/3/25 at 4:49 p.m., Resident 90 stated, Lunch was not good. The pureed food had no taste and was gummy in texture. During a Resident Council meeting on 12/4/25 at 11:25 a.m., attendees stated meat was often overcooked, baked chicken was like jerky, and the pizza was like cardboard. During an interview on 12/4/25 at 12:34 p.m. with Resident 51, Resident 51 described the lunch as, Absolutely forgettable, and commented that kitchen staff should learn how to cook. During an interview on 12/4/25 at 2:20 p.m., the Registered Dietitian (RD) stated palatability was a concern as it could reduce intake and cause unplanned weight loss for the residents. During an interview on 12/5/25 at 11:21 a.m., Resident 89 reiterated their dissatisfaction with the food, stating, Still hate the food. A review of the facility's undated policy and procedure (P&P) titled, Food Handling Practices indicated, The objectives of good food preparation are to. Serve foods which are attractive, palatable, and in the form best tolerated/accepted by residents .		

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on observation, interview, and record review, the facility failed to provide drinks consistent with resident preferences for six residents (Residents 21, 29, 33, 43, 69, and 74) of 16 sampled residents when hot beverage service was unavailable for over two weeks. This failure caused the residents to feel unhappy and dissatisfied with the dietary services provided. Findings: A review of Resident 21's admission record indicated admission to the facility on 2/7/18 and the resident was the responsible party (RP - person responsible for making decisions for the resident). A review of Resident 69's admission record indicated admission to the facility on 8/26/21 and resident was the RP. A review of Resident 29's admission record indicated admission to the facility on 7/26/22 and spouse was the RP. A review of Resident 43's admission record indicated admission to the facility on 7/29/23 and resident was the RP. A review of Resident 74's admission record indicated admission to the facility on 4/19/24 and a non-related person was the RP. A review of Resident 33's admission record indicated admission to the facility on 6/13/24 and resident was the RP. During a concurrent observation and interview in Resident 74's room on 12/3/25 at 8:08 a.m. Resident 74 was awake and alert. Resident 74 stated the facility had not served any coffee in about two weeks. Resident 74 stated it was a problem. During an interview in Resident 33's room on 12/3/25 at 8:10 a.m., Resident 33 stated the facility had not had coffee for three weeks. Resident 33 stated it was a problem. Resident 33 also stated he drank coffee every day when he was at home. During an interview in Resident 43's room on 12/3/25 at 8:20 a.m., Resident 43 stated he had not had coffee in a while. Resident 43 stated it was a problem that he had not had coffee. During an interview in Resident 29's room on 12/3/25 at 8:25 a.m., Resident 29 confirmed he also had not had any coffee in a while, and it was a problem for him. Resident 29 stated it had been two weeks, and he liked to drink coffee. During an interview in Resident 21's room on 12/3/25 at 9:02 a.m., Resident 21 stated her only issue with food service was she had not been served coffee. Resident 21 stated she wanted to have coffee, and it was a problem for her. During an interview in Resident 69's room on 12/4/25 at 11 a.m., Resident 69 stated the tap water was a good temperature for her except it was not hot enough to make a cup of tea. Resident 69 stated she has not had access to hot water to make tea for several weeks. She also stated she was unhappy that she could not make hot tea as that was one of her preferred beverages, especially during the winter. During an interview on 12/5/25 at 9:30 a.m. the Dietary Manager (DM) stated the facility coffee maker broke down sometime before Thanksgiving (11/27/25). The company representative for the coffee supplier took away the old machine and installed a temporary machine. The temporary machine made one pot of coffee and had a hot water spigot for tea and hot cocoa. The company representative did not check the temperature of the coffee or the water used for tea and cocoa before he left the facility. The DM stated the Administrator (ADM) decided the machine could be used for the daily coffee social (a social event in the dining room where the residents had been served coffee, tea, or cocoa according to their individual preferences). During the coffee social the Activities Director noticed the temperature of the water and coffee was too hot to serve and she notified the ADM. The ADM notified staff that the temporary coffee machine would not be used to provide hot beverages for any of the residents. The DM asked the company representative to return to the facility to adjust the water temperature of the temporary machine, but the representative did not return. The DM stated when she walked around the facility residents had repeatedly asked her about getting coffee served and they had stated they were not happy they did not get any coffee. The DM confirmed she would be very unhappy if she had not had access to coffee or tea. During a concurrent observation and interview on 12/5/25 at 10:14 a.m. in the ADM's office, there were two large containers of coffee with cups and condiments on the ADM's desk. The ADM stated he brought in coffee every week as a treat for his staff. The ADM also stated the lack of coffee or other hot beverages did not affect the quality of life for the residents. He stated he had not allowed staff to (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Pine Ridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 45 Professional Center Pkwy San Rafael, CA 94903	
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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	serve the residents any hot beverages during coffee social as the temporary coffee machine produced coffee and water that was scalding hot. The ADM stated residents enjoyed attending the coffee social where they had coffee, tea, and hot chocolate, but that had not been an option since the coffee machine broke sometime before Thanksgiving. The ADM stated residents had asked him repeatedly when they would be served coffee. A review of a facility document titled, [Company Name] Healthcare Fall/Winter 2025, Week 1, House Diet indicated coffee or tea was on the menu for every breakfast, lunch, and dinner. A review of the menu for Week 2 also indicated coffee or tea was on the menu for every breakfast, lunch and dinner. A review of the facility's policy titled, Resident Food Preferences, undated, indicated, Individual food preferences will be assessed upon admission and communicated to the Interdisciplinary Team [a group of professionals from different areas of the facility who work together to provide comprehensive patient centered care].		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a safe discharge for one resident (Resident 100) of four sampled residents when Resident 100 required assistance with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and was discharged to an Independent Living Facility (ILF) that did not provide assistance. This failure decreased the facility's potential to ensure the Resident 100's continuity of care needs was met upon discharge into the community. Findings: A review of Resident 100's resident face sheet indicated admission to the facility on 7/18/25 with diagnoses of Sepsis (life threatening infection) and Infection and inflammatory reaction (a body's response to harmful stimuli such as infection or injury) due to an internal left hip prosthesis (an artificial implant to replace damaged hip joint). A review of Resident 100's care plan, dated 7/18/25, indicated Resident 100 wished to return to the community upon discharge. Resident 100's goal was to return to the community safely. To assist Resident 100 achieve this goal, facility staff were expected to identify a safe place for Resident 100 to go to after discharge from the facility; provide information and assistance with community resources that Resident 100 could use; and call Resident 100 within 24 to 72 hours after discharge from the facility to conduct a welfare check. A review of Physical Therapy notes titled PT Discharge Summary, dated 11/24/25 indicated, Discharge Location = [Resident 100] discharged to Group Home. Assistance/ Support to be Provided = AM [morning] assistance/ caregiver available, PM [evening] assistance/caregiver available. A review of Resident 100's progress notes indicated the following regarding his discharge planning: A note dated 11/4/25 at 4:56 p.m. indicated, [Resident 100] uses a wheelchair to aid him in ambulation. Resident [100] is able to walk using a FWW [front wheeled walker] with contact guard assist [when a caregiver uses a light touch, often with one or two hands, to help someone with balance and stability during a movement (like walking or transferring) to provide safety presence]. he is assisted with meals as staff needs to set up. [Resident 100] needs one-person physical assist with bathing. A note dated 11/20/25 at 6:50 p.m. indicated, [Resident 100] has agreed to be discharged to an [ILF]. [Elder Care Advisor (ECA)] will meet [Resident 100] tomorrow afternoon. A note dated 12/2/25 at 7:26 p.m. indicated, [Resident 100] was discharged today to an [ILF]. He uses a wheelchair and FWW to aid him with ambulation as he is still non full weight bearing related to hip surgery. A review of Resident 100's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 12/2/25, indicated a Brief Interview for Mental Status (BIMS, and assessment tool use by facilities to screen and identify memory, orientation, and judgment status of the resident) score of 15 of 15 which indicated no cognitive impairment. A review of Resident 100's functional abilities in this MDS indicated Resident 100 required supervision or touching assistance with showering/bathing self; tub/shower transfers; walking 10 feet, walking 50 feet with two turns, walking 100 feet, walking 10 feet on uneven surfaces, 1 step or curb, 4 steps, 12 steps and picking up an object. During an interview on 12/4/25 at 11:24 a.m., the SSD stated Resident 100 used a wheelchair and could not walk long distances. The SSD stated both the ILF and the ECA from an assisted living locator company told her the ILF would provide help for Resident 100 while he resided there. The SSD stated the assisted living locator company found the ILF for her and she believed them. The SSD further stated, It was a bad choice. During an interview on 12/4/25 at 11:59 a.m., the Administer (ADM) stated he was heavily involved in Resident 100's discharge as Resident 100 owed a great deal of money to the facility. The ADM acknowledged the assisted living locator company helped the SSD to find placement for Resident 100. During an interview on 12/4/25 at 2:10 p.m., the ECA from the assisted living locator company acknowledged her role was to provide assistance to healthcare facilities to find placement for residents who needed assisted living. The ECA stated she introduced the manager of the ILF to the SSD but knew ILFs would not take individuals who were not (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completely independent. The ECA stated ILFs were Room and Board facilities which provided lodging, not Board and Care which provided assistance with daily needs. The ECA denied telling the SSD the ILF would provide ongoing assistance to Resident 100. During an interview on 12/5/25 at 10:12 a.m., the Manager (MGR) of the ILF stated when Resident 100 arrived to the facility on [DATE], he was caught off guard when Resident 100 told him he could not walk. The medical transport van dropped him off at the end of the driveway, when both Resident 100 and the MGR realized Resident 100 could not stay at the facility. The MGR stated the ILF was not wheelchair accessible, nor was the bathroom. One of the residents at the ILF offered to carry Resident 100 upstairs to his room and bathroom until a different location could be found for Resident 100. The MGR stated, Obviously, this was not sustainable. I would not have accepted him if I knew he couldn't walk. He spent one night here. He left on the morning of 12/3/25 to the hospital, complaining of chest pain. The MGR stated he attempted to call the SSD and the ECA but could not reach either one of them. In an interview on 12/5/25 at 12:52 p.m., Resident 100 stated he had asked the SSD if the facility they were sending him to would be able to assist him and the SSD stated they would. Resident 100 stated he agreed to the discharge because he trusted the SSD. Resident 100 stated when he arrived to the ILF, the staff told him they would not be able to provide the assistance he needed. Resident 100 stated he was unable to cook and needed assistance setting up his food so he did not eat between the time he was discharged from the facility until he arrived to the hospital. A review of facility policy titled Transfer and Discharge, undated, indicated In determining the discharge location for a resident, the decision to discharge to a particular location will be determined by the needs, choices and best interests of that resident.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, nursing staff failed to develop a care plan for one resident (Resident 53) when there was no care for Resident 53's use of oxygen therapy. This failure decreased the facility's potential to meet Resident 53's needs, as well as cause a decline in Resident 53's physical health and emotional well-being. Findings: A review of Resident 53's face sheet indicated admission to the facility on 8/23/25 with a diagnosis that included Chronic Obstructive Pulmonary Disease (COPD, a progressive lung condition making it hard to breathe, encompassing chronic bronchitis (inflamed airways, mucus) and emphysema (damaged air sacs), Pleural Effusion (the buildup of excess fluid in the pleural space, the area between your lungs and chest wall), and Atelectasis (the partial or complete collapse of a lung or a lobe, occurring when tiny air sacs (alveoli) deflate, preventing proper oxygen exchange. A review of Resident 53's physician order report indicated Resident 53 had an order to receive supplemental oxygen at 2-3 liters per minute (LPM) and licensed nurses were expected to check Resident 53's pulse at least once during every shift starting on 9/18/25. A review of Resident 53's care plans dated 9/18/25 to 9/25/25 did not include a care plan for oxygen therapy. During an initial observation on 12/2/25 at 10:30 a.m., Resident 53 was sitting up in bed awake and alert. Resident 53 was wearing a nasal canula and her oxygen concentrator was set at 2 liters (L, a unit of measurement) of humidified oxygen. During an interview on 12/4/25 at 4 p.m., Licensed Nurse 6 (LN 6) confirmed there was no care plan for Resident 53's oxygen therapy. During a review of the facility's undated policy and procedure titled, Care Plan Essentials (CPE) indicated, By providing a centralized care summary, resident care experiences will improve, as the nursing staff will have important care and safety data related to individualized care and treatment of the resident. CPE includes the following resident-specific information. Respiratory. The Licensed Nurse will update the CPE information during shift-to-shift reporting/endorsement. The Licensed Nurses will utilize the CPE during shift-to-shift reporting and may update when indicated. The Ambassador assigned to the resident may also update the CPE. The company's Director of Staff Development/Designee will review for the accuracy of information in CPE during the morning meeting. When an update in any section is indicated, a new CPE will be initiated.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to provide communication services to one resident (Resident 8) out of 21 sampled residents when translation services were not used to communicate with Resident 8 whose primary language was Mandarin. This failure decreased the facility's potential to prevent a decline in Resident 8's ability to perform Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and a decline in ensuring Resident 8 received necessary care and services. Findings: A review of Resident 8's face sheet indicated admission to the facility on [DATE] with diagnoses of Tubulo-Interstitial Nephritis (a type of kidney disease which involves damage to the small tubes and surrounding tissue in the kidney) and Malignant Neoplasm of the Breast (breast cancer). A further review of this face sheet indicated Resident 8's preferred language was Chinese, but no specific dialect of Chinese was documented. During an observation in Resident 8's room on 12/2/25 at 2:39 p.m., Resident 8 was lying in bed gesturing toward the wall and pointing at her bedside table. Resident 8 would not speak, just grunted as she pointed to the bedside table. During a phone interview on 12/4/25 at 7:55 a.m., Resident 8's Responsible Party (RP, an individual or entity legally accountable for specific financial, legal, and health care obligations) stated Resident 8 spoke very little English, and Mandarin Chinese was her preferred language. The RP stated Resident 8 has become frustrated with her limited ability to communicate with the staff. The RP stated at times, Resident 8 wanted to talk to staff about her inability to sleep because of her roommate, or about her current level of pain. During an interview on 12/5/25 at 8:55 a.m., Licensed Nurse 5 (LN 5) stated he was frequently assigned as Resident 8's nurse. LN 5 stated he attempted to communicate with her non-verbally, but stated, It's kind of hard sometimes. LN 5 stated he sometimes used a translation application on his personal cell phone, but admitted he was unsure of Resident 8's dialect of Chinese. LN 5 further stated he was unsure if the facility offered translation services to their residents. LN 5 stated it was important for residents and staff to understand each other for resident safety. During an interview on 12/5/25 at 9:01 a.m., LN 4 stated she used the translation application on her phone to work with her residents who did not speak English, including Resident 8. LN 4 stated she was unsure of Resident 8's dialect. LN 4 stated she was unaware of any translation services provided by the facility. During a concurrent interview and document review on 12/5/25 at 10:06 a.m., the Administrator (ADM) motioned toward the translation services flyer posted in the kitchen hallway. The ADM stated translation services were reviewed and encouraged during staff orientation. A review of the facility's translation service invoices between April 2025 and November 2025 indicated Mandarin Chinese translation service was used twice on 4/13/25 for a total of 9 minutes. A review of the facility's policy titled Communication with Persons with Limited English Proficiency, undated, indicated, [The facility] will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. [The facility] will conduct a regular review of the language access needs of our patient population. [The facility] shall promptly identify the language and communication needs of the LEP person. If necessary, staff will use a language identification card or posters to determine the language. The administrator is responsible for obtaining an outside interpreter if a bilingual staff or staff interpreter is not available. Translators are available 24 hours per day via [translator services].		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on interview and record review, facility staff failed to ensure one resident (Resident 67) of 21 sampled residents was screened for a need for trauma-informed care when upon admission. This failure decreased the facility's potential to provide culturally competent care that minimized triggers or further traumatized Resident 67. Findings: A review of Resident 67's face sheet indicated admission to the facility on 2/4/25 with diagnoses of hemiplegia (complete paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following a cerebral infarction (stroke) affecting right dominant side and post-traumatic stress disorder (a mental health disorder that can develop after experiencing or witnessing a life threatening or shocking traumatic event). A review of Resident 67's care plans indicated the following: A care plan dated 2/4/25 indicated Resident 67 had behavioral problems with verbal outbursts. Resident 67's goal for this behavior was to be diverted into a productive and meaningful activity. To reach this goal, staff were directed to remove [Resident 67] from triggering environment to a calm and quite [sic] place with supervision. A care plan dated 3/31/25 indicated Resident 67 was agitated and verbalized anxiety. Resident 67's goal was to have decreased episodes of anxiety. To reach this goal, staff were directed to identify and attempt to remove anxiety triggers. During a concurrent observation and interview in Resident 67's room on 12/2/25 at 2:52 p.m., Resident 67 was observed pacing about his room with a seated walker (a wheeled mobility aids with a built-in seat and often a backrest). Resident 67 stated, I don't feel safe here. Resident 67 further stated he was feeling threatened by the resident across the patio and wished he had a gun to protect himself. During an interview on 12/4/25 at 10:13 a.m., Licensed Nurse 2 (LN 2) stated she was often assigned to care for Resident 67. LN 2 stated she was unsure what triggered Resident 67's behavior. LN 2 spoke of an incident which occurred earlier that morning where a resident was loudly singing which caused Resident 67 to slam his door and scream. LN 2 stated another time, Resident 67 became so frightened, he approached LN 2 and told her he was being followed by another resident and to make him stop. During an interview on 12/4/25 at 11:02 a.m., the Social Services Director (SSD) stated residents who experienced trauma should have a care plan initiated right away for the best care. The SSD stated the facility used a Trauma Informed Care screening form upon admission. The questions and content of this form would reveal traumatic events that occurred in the resident's life, which would help formulate the care plan for trigger mitigation or elimination. The SSD confirmed Trauma Informed Care screening was not completed for Resident 67 but understood how it would have benefitted him. A review of the facility's policy titled Trauma Informed Care, undated, indicated, Caregivers are taught strategies to help eliminate, mitigate or sensitively address a resident's triggers. Nursing staff and Social Services staff are trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization. The designated staff will conduct the Trauma Informed Care (TIC) assessment tool within seven (7) days of admission to identify any history of trauma and any current event or diagnosis of trauma, including possible signs/symptoms through interviews of resident/patient, and if available, interviews of resident/patient-representative(s), significant other(s), and family member(s). Medical records review will also be conducted by the designated staff to identify any history of trauma, any current diagnosis and/or signs/symptoms of trauma.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure respiratory equipment was clean and in a usable state for one resident (Resident 76) out of 21 sampled residents when the rented oxygen concentrator in Resident 76's room had visible dust and debris in the vents and needed a filter change. This failure decreased the facility's potential to prevent bacteria and debris directly enter Resident 76's lungs, placing her at risk for infection. Findings: A review of Resident 76's face sheet indicated admission to the facility on 8/30/22 with diagnoses of Community Acquired Pneumonia (a lung infection contracted outside of the facility) and Adult Failure to Thrive (a state of significant physical and functional decline in older adults). A review of Resident 76's physician orders, dated 10/28/25, indicated, Oxygen 2-4 L [liters, a unit of measure] via nasal canula [flexible device used to deliver oxygen through the nose] for saturation [the amount of oxygen carried in your blood as a percentage of the maximum it could carry] < [less than] 90%. During an observation on 12/2/25, at 11:06 a.m., in Resident 76's room, an oxygen concentrator (a medical device that pulls air from the surrounding environment, filters out impurities and delivers medical-grade oxygen to residents with a respiratory condition) was seen against the wall near Resident 76's bed. The oxygen concentrator was noted to have visible debris on the front of the machine. The filter used to clean and purify the air was black and needed to be changed. The vents near the filter had accumulated dust build up. During an interview on 12/5/25 at 8:19 a.m., the Director of Nursing (DON) stated the oxygen concentrators were rented from a local company and the facility's maintenance department was responsible for daily checks of the equipment. During an interview on 12/5/25 at 8:21 a.m., the Maintenance Director (MNT) stated the oxygen concentrators were checked daily by housekeeping. The MNT acknowledged the oxygen concentrator in Resident 76's room was not clean and in a usable condition. The MNT stated that because the equipment was rented, he was not sure of the process for checking for functionality and cleanliness, further adding the rental company made weekly visits to check on the state of the equipment. During an interview on 12/5/25 9:25 a.m., the Infection Preventionist (IP) stated using a dusty oxygen concentrator with a dirty filter placed the resident at risk. The IP stated the oxygen concentrator could blow particles from the dust and debris found on the concentrator into the residents' lungs and could cause an infection or illness. She further stated filters on the oxygen concentrators should be changed weekly. During an interview on 12/5/25 at 8:48 a.m., the Administrator (ADM) stated the facility was responsible for maintaining cleanliness of the equipment and has not been following their own policy. A review of the facility's policy titled Cleaning Respiratory Equipment, undated, indicated, The Company provides and maintains clean respiratory equipment. Wipe down all concentrators. Clean oxygen concentrator filters weekly.		